WOODROW WILSON REHABILITATION CENTER
Field Rehabilitation Services Policy

W.W.R.C. Admissions Criteria

It is our intention to accept for admission any individual with a disability whose needs are compatible with the structure, staff, and other WWRC resources. Primary consideration is given to DRS clients pursuing vocational goals. For non-DRS referrals, contact the Admissions Department directly for the application process: 540 332-7065.

- Applicants must be medically, physically and psychologically stable and have a favorable prognosis to complete and benefit from the services requested. Applicants with a psychiatric diagnosis must show six (6) consecutive months stability in the community. Exceptions to the six months stability may be considered if the consumer is willing to participate in an outpatient evaluation at WWRC to determine feasibility for services and admission contingencies.

  Current documentation from a physician, mental health or other professional providing treatment or diagnostic services may be requested.

  Applicants with a history of substance abuse must have six (6) consecutive months of documented abstinence or demonstrated completion of intense substance abuse treatment and active participation in a substance abuse aftercare program (12- step support groups alone do not qualify as intense treatment or aftercare). Exception may be considered if the consumer is willing to participate in an outpatient evaluation at WWRC to determine feasibility for services and admission contingencies.

- Applicant's current behavior will not jeopardize the health, safety, or rehabilitation program of self or others at the Center.

- Applicants must be 18 years of age or older to be admitted for residential services, unless they are requesting a program designed and staffed for minors.

- Applicants must be willing and able to comply with WWRC community living standards (Rules & Regulations).

- Applicants, in conjunction with the referral source, must have a viable plan for community reintegration (discharge plan) addressing residential options as well as community support service needs.

  * *Applicants are required to have a plan for immediate removal from WWRC if deemed necessary.

- Applicants must have an identified funding source. All funding sources should be identified to the extent possible, especially third party insurers and primary care physicians.

- Applicants must have any court charges against them settled prior to seeking admission. Cases that are pending adjudication through the judicial system will not be considered. WWRC is not an alternative placement option.

INFORMATION REQUIRED FOR PROCESSING AN APPLICATION FOR ADMISSION

1. WWRC Client Referral Form. (Required for all applications including Outpatient Services.)
2. WWRC Client Application for Admission. (Application process not required for Outpatient Services.)
3. For all clients with active medical/mental health conditions, a recent (within 60 days) medical report from treating physician/clinician is required. If admission is delayed, an updated medical may be required.
4. Psychological reports (including subtest scores) when available; also academic level and counselor administered test results.
5. Social history. This must describe home, family, and community situation. It should also record any information from courts, mental hospitals, or correctional institutions. (DRS-RS4; RS4-0)
6. Educational history, giving academic achievement and school adjustment should be provided for all. For those under 18 years of age who have received special education services, a copy of the most recent eligibility summary and IEP from the LEA needs to be included. (DRS-RS4; RS4-0) If applicant is under 22, final high school transcript is required for pre-vocational and/or vocational training.
7. Work history - as complete as possible. (RS4-0) Employment Plan if applicable.
8. RS-13 and copy of tax return (if available) for individuals under an IPE. If client is not fully funded by DRS for vocational program, RS 15 (WWRC financial participation form) is required.

*** Additional information may be requested on an individual basis.**

The Woodrow Wilson Rehabilitation Center provides services without discrimination regarding race, color, creed, sex, national origin, age, or disability in compliance with Title VI of the Civil Rights Act of 1964 and the Disability Act of 1990. All applicants have the right to file complaints and to appeal decisions according to regulations governing this process.

ADMISSION OFFICE CONTACTS AND PHONE NUMBERS: (WWRC 1-800-345-9972 / FAX 540-332-7307)

These staff are available to answer questions about specific programs, next available dates, general criteria, and active referrals.		PHONE	EMAIL @WWRC.Virginia.gov
Program Manager	Greta Hedberg	(540) 332-7052	Greta.Hedberg
Pre-admission Tech – Vocational	Jayne Tooley	(540) 332-7012	Jayne.Tooley
Pre-admission Tech – Vocational	Natasha Benenson	(540) 851-2508	Natasha.Benenson
Pre-admission Tech - Brain Injury Services-STRU	Marjorie Adcock	(540) 332-7493	Marjorie.Adcock
Pre-admission Tech - PERT Offsite Evals	Rita Jones	(540) 332-7015	Rita.Jones
Pre-admission Tech- Outpatient/ Medical Mobile Clinics/Driving	Robyn Jarvis	(540) 332-7948	Robyn.Jarvis
Pre-admission Tech - Outpatient/Medical ART Evals	Joanne Eimers	(540) 332-7017	Joanne.Eimers

APPEALS PROCESS:

Appeals of WWRC admission decisions shall be addressed through FRS Counselor and Manager review. If the admission is supported by the FRS Manager with supporting documentation, the applicant's denial will be reconsidered by the WWRC admission committee. If resubmitted and denied, the Regional Directors will be consulted through the Operations Committee. The Applicant has the right to file a fair hearing should they choose.

WOODROW WILSON REHABILITATION CENTER
Fishersville, Virginia 22939
REFERRAL FORM

FROM:

Referral Source: _____ Counselor #: _____ Date: _____

Office/Address: _____ Telephone #: _____

_____

Client Name: _____ WWRC #: _____

Social Security #: _____ DRS Case ID#: _____

Disability: _____ RSA Code (s): _____

_____ FAX #: _____

This is a: ☐ referral with full DRS sponsorship ** Medical insurance will be billed first

☐ referral with partial DRS sponsorship (Vocational programs only)

(Client/Family to pay _____ % of charges up to $ _____)

☐ Other ☐ Workman's Comp

DRS status upon arrival at WWRC: _____ Days Authorized: _____

Referral: (Goals/Comments)

ATTACHMENTS: (INFORMATION REQUIRED FOR PROCESSING ADMISSION APPLICATION)

☐ WWRC Client Application for Admission. (Application process not required for Outpatient Services.)

☐ For all clients with active medical/mental health conditions, a recent (within 60 days) medical report from the treating physician/clinician is required. If admission is delayed, an update may be required prior to admission.

☐ Psychological reports (including subtest scores) when available; also academic level and counselor administered test results.

☐ Social history. This must describe home, family, and community situation. It should also record any information from courts, mental health facilities, or correctional institutions. (DRS-RS4; RS4-0)

☐ Educational history, giving academic achievement and school adjustment should be provided for all. For those under age of 18, who have received special education services, a copy of the most recent eligibility summary and IEP from the LEA needs to be included. (DRS-RS4; RS4-0) If applicant is 22 and under, final high school transcript is required.

☐ Work history - as complete as possible. (RS4-0)

☐ IPE if applicable.

☐ RS-13 and copy of tax return (if available) for individuals under an IPE. If client is not fully funded by DRS for vocational program, RS15 (WWRC financial participation form) is required.

- Additional information may be requested on an individual basis.

W.W.R.C. REFERRAL FORM - PAGE 2 **CLIENT NAME:** _____

PROGRAM REQUESTED:

☐ **Vocational Evaluation**
- ☐ Feasibility Interview ☐ Fast Track ☐ Work Sample(s) ☐ Skills Assessment
- ☐ Re-Evaluation (under 12 months) Reason? _____

☐ **Life Skills Transition Program**

☐ **Vocational Training**
Curriculum: _____

☐ **Brain Injury Services (BIS)** OP Evaluation Clinic – Neuro psychological Evaluation

☐ **PERT** ☐ Initial Evaluation ☐ Situational Assessment (Supplemental)

☐ **Short Term Rehabilitation Unit (STRU)**

☐ **Outpatient Evaluation**

SUPPORT SERVICES REQUESTED: (check all that apply)

☐ **Physical Therapy**
- ☐ General Evaluation/Therapy
- ☐ Wheelchair/Seating Evaluation
- ☐ Orthotic/Prosthetic Evaluation
- ☐ Functional Work Capacities Evaluation

☐ **Occupational Therapy**
- ☐ General Evaluation/Therapy
- ☐ Independent Living Skills
- ☐ Visual/Perceptual/Cognitive Skills

☐ **Communication Services**
- ☐ Hearing Evaluation
- ☐ Speech Evaluation/Therapy
- ☐ Aphasia/Cognitive Language Eval/Therapy

☐ **Behavioral Health**
- ☐ Feasibility Interview
- ☐ Psychological Evaluation
- ☐ Academic/Intellectual/L.D. Testing
- ☐ Neuropsychological Testing
- ☐ Individual Treatment Plan

☐ **Assistive & Rehabilitative Technology**
- ☐ Augmentative Communication
- ☐ Assistive Computer Technology (ACT)
- ☐ Rehabilitation Engineering
- ☐ General Evaluation

☐ **Academic Support Services**
- ☐ Adult Basic Education (ABE)
- ☐ GED Assistance/Prep Test

☐ **Special Population Services: DBVI & Deaf, Hard of Hearing, ESL**

☐ **Driving Program**
- ☐ Evaluation ☐ Training ☐ Adaptive

☐ **Other** _____

RESIDENCE REQUESTED: (check only one)

☐ Attendant Care -- Supported Living Service (SLS) / Short Term Rehab Unit (STRU)

☐ Dormitory (can live safely & independently)

☐ Day Student

WOODROW WILSON REHABILITATION CENTER
Fishersville, VA 22939
CLIENT APPLICATION FOR ADMISSION

LAST NAME: _____ FIRST: _____ MIDDLE: _____

SOCIAL SECURITY #: _____ BIRTH DATE: _____

CLIENT'S HOME ADDRESS: _____ MARITAL STATUS: S☐ M☐ D☐ W☐ E☐

_____ HOME TELEPHONE #: _____

_____ CELL PHONE #: _____

EDUCATION:

☐ Enrolled in school _____ Grades completed?

DIPLOMA ☐ High School ☐ GED **IEP** ☐ Modified Standard ☐ Completion Certificate

☐ Special Education under 18 (needs I.E.P. & Eligibility summary)

☐ College (How many years completed?)_____

DRIVER'S LICENSE: ☐ YES ☐ NO **LEARNER'S PERMIT** ☐YES ☐NO

ORIGIN OF DISABILITY:

Onset Date: _____

Disability related to: ☐ **work** ☐ **crime** ☐ **home** ☐ **military** ☐ **congenital**
☐ **sports** ☐ **motor vehicle** ☐ **Other** _____

Is there any legal action pending or contemplated as a result of your injury?: (select one) ☐ YES ☐ NO

Lawyer's Name/Address: _____

LEGAL STATUS:

Have you been or are you currently: (select one)
- on probation? ☐ YES ☐ NO
- on parole? ☐ YES ☐ NO
- awaiting trial on criminal charges? ☐ YES ☐ NO

If you responded YES to any of the above legal status questions, please give details:

_____

INSURANCE/SPONSORSHIP: (for medically necessary services and/or medical emergencies)

Do you have medical insurance coverage? ☐ YES ☐ NO

Name of Insurance Company: _____

Billing Address: _____

Telephone #: _____ Policy/Social Security #: _____

Policyholder Name: _____ Type of Policy: ☐ GROUP ☐ INDIVIDUAL

If Group Policy, please give GROUP #: _____

Employer Name: _____ Telephone #: _____

Employer Address: _____

Medicare #: _____ Medicaid #: _____

CLIENT APPLICATION FOR ADMISSION (MEDICAL)

CLIENT NAME: _____

PHYSICIAN'S NAME: _____

PHYSICIAN'S ADDRESS: _____ **PHYSICIAN'S** Telephone# Fax # _____

Have you ever been treated by a physician for any of the following?

	YES	NO
Heart Problems	☐	☐
Kidney Problems	☐	☐
Breathing Problems	☐	☐
Seizure Disorder	☐	☐
Date of last seizure: _____		
Infections: MRSA, VRE, TB, OTHER	☐	☐
Name of infection: _____		
Other health problems? _____		
_____		
List operations: _____		
_____		

	YES	NO
Do you need a special DIET?	☐	☐
If yes, what type? _____		
Have you had a TETANUS SHOT?	☐	☐
If yes, when? _____		
Do you have any ALLERGIES?	☐	☐

(List any allergies you have to medications, food, etc.)

_____

_____

	YES	NO
Are you taking any MEDICATIONS?	☐	☐

(List the names of the medications you are taking and how many times per day you take them.)

_____

_____

_____

_____

_____

Activities of Daily Living:

	YES	NO
Do you have bowel control?	☐	☐
Do you have bladder control?	☐	☐
Do you need help with:		
- eating?	☐	☐
- dressing?	☐	☐
- transfers?	☐	☐
- toileting?	☐	☐
- bathing?	☐	☐
Do you use a wheelchair?	☐	☐
Can you sit in your chair all day?	☐	☐
Do you have pressure sores? (i.e., skin breakdown)	☐	☐

Do you have problems with any of the following?

Speech	☐	☐
Vision	☐	☐
Hearing	☐	☐
Memory	☐	☐

Do you use any of the following assistive devices?

Glasses	☐	☐
Hearing Aid(s)	☐	☐
Walker/crutch/cane	☐	☐
Guide Dog	☐	☐
Blind cane travel	☐	☐
Prosthesis	☐	☐
Orthosis	☐	☐

Do you have Home Health Services?	☐	☐

How often do you see your physician?

_____

Weight _____ **Height** _____

Clients or their authorized guardian (if applicable) who have existing ADVANCE DIRECTIVES are solely responsible for making this known to the case manager and physician responsible for their care and treatment at WWRC. A copy of the ADVANCE DIRECTIVE must be brought with you and will become a part of the Medical Record.

CLIENT APPLICATION FOR ADMISSION

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CONSENT TO ADMISSION/RELEASE OF INFORMATION

I hereby consent to admission to WWRC and give permission to WWRC, its physicians, and staff to administer such treatment, medication, or procedure upon me as they, in their professional judgment, may deem advisable in the care and treatment of my case. I understand that prior to the administration of any treatment, medication, or procedure, I will be advised of the risks and benefits of the proposed treatment, that any questions I have concerning the proposed treatment will be answered and that I have a right to refuse or withdraw consent to the proposed treatment and to discuss the implication of the refusal with my physician (treatment team), including its impact on my health care needs and the ability of WWRC to continue to provide treatment to me. In the event of an emergency, I authorize WWRC to provide such treatment as may be deemed necessary in its professional judgment, to prevent death, serious bodily injury, or serious deterioration in my condition. In an emergency situation requiring surgery, I authorize such surgery to be performed upon me in any qualified hospital to which I may be transferred.

Permission is granted for any physician, psychologist, hospital, school, or other professional or facility to release to the Woodrow Wilson Rehabilitation Center any records concerning me as may be requested by officials of WWRC.

This client application has been fully explained to me and I certify that I understand its contents and it is complete and accurate to the best of my knowledge. A photocopy of this form shall be valid as the original.

Client's Full Name (Please Print): _____

Signature of Client: _____ Date: _____

Witness: _____ Date: _____

Signature of Parent, Legal Guardian (if under 18 years of age), Power-of-Attorney, or Closest Relative:

X: _____ Date: _____

Witness: _____ Date: _____

REMOVAL RESPONSIBILITY – If termination of enrollment becomes necessary, I agree to remove the above-named client from Woodrow Wilson Rehabilitation Center immediately upon notice. (Signature of someone other than applicant required.)

Name (Please Print): _____ Home #: _____

Address: _____ Work #: _____ Cell #: _____

_____ Relationship to Applicant: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

EMERGENCY NOTIFICATION PERSON: (if different from above)

Name: _____ Relationship: _____

Address: _____

Home #: _____ Work #: _____ Cell #: _____